Senate Study Bill 3140

SENATE FILE _____
BY (PROPOSED COMMITTEE ON HUMAN RESOURCES BILL BY CHAIRPERSON RAGAN)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to health care reform in Iowa including the Iowa health care coverage exchange; medical homes; prevention and chronic care management; the Iowa health information technology system; health care quality, consumer information, strategic planning, and resource development; and the certificate of need program.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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DIVISION I
IOWA HEALTH CARE COVERAGE EXCHANGE

Section 1. NEW SECTION. 514M.1 SHORT TITLE.

This chapter shall be known and may be cited as the "Iowa Health Care Coverage for All Act".

Sec. 2. NEW SECTION. 514M.2 DECLARATION OF INTENT.

It is the intent of the general assembly in enacting this chapter, as funding becomes available, to progress toward achievement of the goal that all Iowans have health care coverage with the following priorities:

1. The goal that all children in the state have qualified health care coverage which meets certain standards of quality and affordability with the following priorities:

a. Covering all children who are declared eligible for medical assistance, the state children's health insurance program, and hawk=i by December 31, 2009.

b. Subsidizing qualified health care coverage, which meets certain standards of quality and affordability, for the remaining uninsured children up to eighteen years of age under a sliding scale based on family income by December 31, 2009.

c. Moving toward a future requirement that all parents must provide proof of qualified health care coverage which meets certain standards of quality and affordability for their children.

2. The goal that all Iowans have qualified health care coverage which meets certain standards of quality and affordability with the following priorities:

a. Continuing to expand options for individuals who are dually eligible for Medicare and medical assistance, typically the chronically disabled, by utilizing evidence=based medical treatments.

b. Facilitating coverage of uninsured health and long=term care workers and child care workers with qualified health care coverage which meets certain standards of quality and affordability.

c. Maximizing eligibility of low=income adults eighteen years of age and older for public health care coverage.

d. Subsidizing qualified health care coverage, which meets certain standards of quality and affordability, for the remaining low=income adults.

e. Moving toward a future requirement that all Iowans must provide proof of qualified health care coverage which meets certain standards of quality and affordability.

3. The goal of decreasing health care costs and health care coverage costs by:

a. Instituting insurance reforms that assure the availability of private insurance coverage for all Iowans by addressing issues involving guaranteed availability and issuance of insurance to applicants, preexisting condition

exclusions, portability, and allowable or required pooling and rating classifications.

b. Requiring every child who has public health care coverage or is insured by a plan created by the Iowa health care coverage exchange to have a medical home.

c. Establishing a statewide telehealth system.

d. Implementing cost containment strategies such as disease management programs, advance medical directives, initiatives such as end=of=life planning, transparency in health care cost and quality information, and an expanded certificate of need process.

Sec. 3. NEW SECTION. 514M.3 DEFINITIONS.

For the purposes of this chapter, unless the context otherwise requires:

1. "Board" means the board of directors of the Iowa health care coverage exchange.

2. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

3. "Commissioner" means the commissioner of insurance.

4. "Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.

d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.

e. 10 U.S.C. ch. 55.

f. A health or medical care program provided through the Indian health service or a tribal organization.

g. A state health benefits risk pool.

h. A health plan offered under 5 U.S.C. ch. 89.

i. A public health plan as defined under federal regulations.

j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. } 2504(e).

k. An organized delivery system licensed by the director of public health.

l. A short=term limited duration policy.

5. "Director" means the director of the department of revenue.

6. "Exchange" means the Iowa health care coverage exchange.

7. "Executive director" means the executive director of the Iowa health care coverage exchange.

8. a. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, "medical care" means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

(3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this subsection, a partnership which establishes and maintains a plan, fund, or program to provide medical care to present or former partners in the partnership or to their dependents directly or through insurance, reimbursement, or other method, which would not be an employee benefit welfare plan but for this paragraph, shall be treated as an employee benefit welfare plan which is a group health plan.

(1) For purposes of a group health plan, an employer includes the partnership in relation to any partner.

(2) For purposes of a group health plan, the term "participant" also includes both of the following:

(a) An individual who is a partner in relation to a partnership which maintains a group health plan.

(b) An individual who is a self=employed individual in connection with a group health plan maintained by the self=employed individual where one or more employees are participants, if the individual is or may become eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive a benefit.

9. a. "Health insurance coverage" means benefits consisting of health care provided directly, through insurance, reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

b. "Health insurance coverage" does not include any of the following:

(1) Coverage for accident=only or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical=payment insurance.

(6) Credit=only insurance.

(7) Coverage for on=site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

(1) Limited scope dental or vision benefits.

(2) Benefits for long=term care, nursing home care, home health care, or community=based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under } 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to individuals under group health insurance coverage.

f. "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan.

10. "Qualified health care coverage" means creditable coverage which meets minimum standards of quality and affordability as defined by the board.

11. "Resident" means a person who is a resident of this state for state income tax purposes.

12. "Secretary" means the secretary of the board of the Iowa health care coverage exchange.

Sec. 4. NEW SECTION. 514M.4 IOWA HEALTH CARE COVERAGE EXCHANGE == BOARD.

1. CREATION == PUBLIC INSTRUMENTALITY. The Iowa health care coverage exchange is created and constitutes a public instrumentality and agency of the state exercising public and essential governmental functions to undertake programs which assist in attainment of the goal of achieving qualified health care coverage for all Iowans. The exchange shall operate under a plan of operation established and approved under section 514M.5.

2. BOARD OF DIRECTORS. The powers of the exchange shall be vested in and exercised by the board of directors of the exchange.

a. The board of directors consists of the following persons who are voting members unless otherwise provided:

(1) The two most recent former governors, or if one or both of them are unable or unwilling to serve, a person or persons appointed by the governor.

(2) The commissioner of insurance, or a designee.

(3) The director of human services, or a designee.

(4) Five members appointed by the governor, subject to confirmation by the senate:

(a) An actuary who is a member in good standing of the American academy of actuaries.

(b) A health economist.

(c) A consumer.

(d) A representative of organized labor.

(e) A representative of an organization of employers.

(5) Four members of the general assembly, one appointed by the speaker of the house of representatives, one appointed by the minority leader of the house of representatives, one appointed by the majority leader of the senate, and one appointed by the minority leader of the senate who shall be ex officio, nonvoting members of the board.

(6) A person who shall serve as the secretary of the board, appointed by the board and who shall be an ex officio, nonvoting member of the board.

b. Each member of the board appointed by the governor shall be a resident of this state and not more than three members shall be members of the same political party.

c. The members of the board appointed by the governor shall be appointed for terms of six years beginning and ending as provided in section 69.19. Such member of the board is eligible for reappointment. The governor shall fill a vacancy for the remainder of the unexpired term. Such member of the board may be removed by the governor for misfeasance, malfeasance, or willful neglect of duty or other cause after notice and a public hearing unless the notice and hearing are waived by the member in writing.

d. The members of the board shall annually elect one voting member as chairperson and one as vice chairperson.

e. A majority of the voting members of the board constitutes a quorum. The affirmative vote of a majority of its voting members is necessary for any action taken by the board. The majority shall not include a member who has a conflict of interest and a statement by a member of a conflict of interest is conclusive for this purpose. A vacancy in the membership of the board does not impair the right of a quorum to exercise the rights and perform the duties of the board. An action taken by the board under this chapter may be authorized by resolution at a regular or special meeting and each resolution shall take effect immediately and need not be published or posted. Meetings of the board shall be held at the call of the chairperson or at the request of a majority of the board's voting members.

f. The members of the board shall not receive compensation for the performance of their duties as members but each member shall be paid necessary expenses while engaged in the performance of duties of the exchange.

g. The members of the board shall give bond as required for public officers in chapter 64.

h. The members of the board are subject to and are officials within the meaning of chapter 68B.

3. EXECUTIVE DIRECTOR. The voting members of the board shall appoint an executive director, subject to confirmation by the senate, to supervise the administrative affairs and general management and operations of the exchange. The board may appoint an assistant executive director, and other officers as the members of the board determine. The officers shall not be members of the board, shall serve at the pleasure of the voting members of the board, and shall receive compensation as fixed by the board.

4. SECRETARY. The secretary of the board shall keep a record of the proceedings of the board and shall be custodian of all books, documents, and papers filed with the board, and the minute book or journal of the board. The secretary shall serve at the pleasure of the board, and shall receive compensation as fixed by the board.

Sec. 5. NEW SECTION. 514M.5 BOARD POWERS == DUTIES.

The board shall have broad authority to accomplish the purposes of this chapter, including but not limited to:

1. Developing a plan of operation for the exchange pursuant to rules adopted under chapter 17A that includes but is not limited to the following:

a. Establishing procedures for operations of the exchange.

b. Establishing procedures for communications with the executive director.

c. Establishing procedures for the selection and approval of qualified health care coverage to be offered through the exchange.

d. Establishing procedures for the enrollment of eligible individuals and groups.

e. Establishing procedures for appeals of eligibility

decisions for the Iowa choice care program.

f. Establishing a plan for operating a health insurance service center to provide eligible individuals and groups with information on the exchange and for managing exchange enrollment.

g. Establishing and managing a system of collecting all premium payments made by, or on behalf of, individuals obtaining health insurance through the exchange, including any premium payments made by enrollees, employees, unions, or other organizations.

h. Establishing and managing a system of remitting premium assistance payments to carriers.

i. Establishing a plan for publicizing the existence of the exchange and the exchange's requirements and enrollment procedures.

j. Developing criteria for determining that certain qualified health care coverage shall no longer be made available through the exchange, and developing a plan to decertify and remove exchange approval from certain qualified health care coverage.

k. Developing criteria for plans eligible for premium assistance payments through the Iowa choice care program.

2. Establishing by rules adopted under chapter 17A what constitutes qualified health care coverage which meets certain standards of quality and affordability by:

a. Setting parameters for what is affordable by creating an affordability schedule that is conservative to prevent harm to people who are struggling financially and that utilizes a progressive scale of subsidization by the state that decreases as incomes increase and requires people with very low incomes to pay only small amounts for health care coverage with no financial penalties.

b. Establishing a program to subsidize health care coverage on a sliding scale based on income for low=income uninsured individuals and families with incomes below three hundred percent of the federal poverty level as determined by the most recently revised poverty income guidelines published by the United States department of health and human services using the following priorities for subsidization of the cost of such coverage by income level as funding becomes available:

(1) Less than one hundred percent of federal poverty level == one hundred percent of the cost subsidized.

(2) One hundred percent to less than one hundred fifty percent of the federal poverty level == eighty percent of the cost subsidized.

(3) One hundred fifty percent to less than two hundred percent of the federal poverty level == sixty percent of the cost subsidized.

(4) Two hundred percent to less than two hundred fifty percent of the federal poverty level == forty percent of the cost subsidized.

(5) Two hundred fifty percent to less than three hundred percent of the federal poverty level == twenty percent of the cost subsidized.

c. Defining what constitutes qualified health care coverage. For purposes of this definition, the board may consider requirements for coverage and benefits that include but are not limited to:

(1) No underwriting requirements and no preexisting condition exclusions.

(2) Portability.

(3) Coverage of physical, behavioral, dental health and vision services, and prescription drugs.

(4) Copayments and deductibles that do not exceed specified amounts. No copayments or deductibles for wellness, prevention, and chronic disease management services.

(5) No reimbursement of providers for an otherwise covered service if the service is required solely on account of the provider's avoidable medical error.

(6) If coverage of an insured's dependents is included, coverage of those unmarried dependents up to twenty=five years of age.

(7) A requirement that all insureds have a medical home.

(8) Coverage of wellness, prevention, and chronic disease management services including without limitation physical and psychosocial screenings for children which satisfy the early periodic screening, diagnosis, and treatment standards of the medical assistance program.

(9) Coverage of emergency mental health services when provided by a certified emergency mental health services provider.

(10) Premium discounts for nonsmokers and for insureds who successfully lose weight through participation in a diet and exercise program prescribed by a qualified health care professional.

(11) A requirement that all participating health care providers:

(a) Utilize electronic prescriptions.

(b) Utilize electronic medical records.

(c) Provide rate schedules to the board for all services offered.

3. Collaborating with carriers to do the following, including but not limited to:

a. Assuring the availability of private qualified health insurance coverage to all Iowans by designing solutions to issues related to guaranteed issuance of insurance, preexisting condition exclusions, portability, and allowable pooling and rating classifications.

b. Formulating principles that ensure fair and appropriate practices related to issues involving individual qualified health insurance coverage policies such as recision and preexisting condition clauses, and that provide for a binding third=party review process to resolve disputes related to such issues.

c. Designing affordable, portable qualified health insurance coverage plans that meet the needs of low=income populations.

4. Designing a health care coverage program called Iowa choice care which offers private qualified health care coverage through the exchange, whose purchase is publicly subsidized on a sliding scale based on income for low=income individuals and families who do not meet eligibility guidelines for any other public health care program, and which provides affordable, unsubsidized qualified health care coverage options for purchase by any other person who wishes to purchase them, including individuals, families, and employees of small businesses. The subsidized portion of the Iowa choice care program may be implemented incrementally as funding becomes available.

5. Designing a subsidy program for payment of premiums for qualified health care coverage by low=income people that complements, not supplants, the medical assistance program. The subsidy program may include subsidizing an employee's purchase of health care insurance offered by that person's employer.

6. Implementing initiatives such as uniform health care insurance applications and other standardized administrative procedures that make the purchase of health care insurance easier and lower administrative costs such as determining what constitutes an equitable administrative formula for carriers.

7. Encouraging initiatives that allow portability of health care insurance between employers for part=time workers, persons who work more than one job, seasonal workers, or people who change jobs.

8. Controlling health insurance coverage premiums by establishing what constitutes reasonable rates, to ensure affordability of coverage.

9. Studying the ramifications of requiring each employer with more than ten employees in this state to adopt and maintain a cafeteria plan that satisfies section 125 of the federal Internal Revenue Code of 1986, and the rules and regulations promulgated by the board.

10. Determining each applicant's eligibility to purchase health care insurance offered by the exchange, including eligibility for premium assistance payments.

11. Seeking and receiving any grant funding from the federal government, departments, or agencies of this state, and private foundations.

12. Contracting with professional service firms as may be necessary, and fixing their compensation.

13. Contracting with companies which provide third=party administrative and billing services for insurance products.

14. Maintaining an office at such place or places in this state as it may designate.

15. Employing persons necessary to carry out the duties of the exchange.

16. Entering into agreements with the department of revenue, the department of human services, the division of insurance, and any other state agencies the board deems necessary to implement its duties under this chapter.

17. Creating, in collaboration with the department of revenue, a form for the department to distribute to every

person to whom it distributes information regarding personal income tax liability, including every person who filed a personal income tax return in the most recent calendar year, informing the recipient of the requirements, if any, to establish and maintain qualified health care coverage.

18. Designing a premium schedule to be published by the exchange by December 1 of each year, which accounting for maximum pricing in all rating factors with an exception for age, includes the lowest premium on the market for which an individual would be eligible for qualified health care coverage. The schedule shall publish premiums allowing variance for age and rate basis type.

19. Developing and implementing a plan and corresponding timeline detailing action steps toward implementing this chapter, by rules adopted pursuant to chapter 17A, as provided in section 514M.8.

20. Commissioning a study to examine and model the effect of merging the individual and small group health insurance markets in this state.

21. Commissioning a study to examine and model the effect of merging the Iowa comprehensive health insurance association and the Iowa health care coverage exchange fund or modifying the association to improve accessibility to qualified health care coverage at reasonably affordable rates prior to complete implementation of health care coverage of all Iowans.

22. Considering changing grouping and rating classifications, including age rating, to better reflect principles of equity, fairness, and cost=sharing, and that best facilitate the goal of achieving quality, affordable health care coverage for all Iowans.

Sec. 6. NEW SECTION. 514M.6 ANNUAL REPORT.

The board shall keep an accurate account of all the activities of the exchange and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to the governor and the general assembly.

Sec. 7. NEW SECTION. 514M.7 HEALTH CARE COVERAGE EXCHANGE FUND == APPROPRIATION.

The health care coverage exchange fund is created in the state treasury as a separate fund under the control of the exchange. All moneys collected from premiums paid for health care plans offered by the exchange, and any other moneys that are appropriated or transferred to the fund shall be credited to the fund. All moneys credited to the fund are appropriated and available to the exchange to be used for the purposes set forth in this chapter. Notwithstanding section 8.33, any balance in the fund on June 30 of each fiscal year shall not revert to the general fund of the state, but shall be available for purposes set forth in this chapter in subsequent fiscal years.

Sec. 8. NEW SECTION. 514M.8 HEALTH CARE COVERAGE FOR ALL == TRANSITION == IMPLEMENTATION.

1. The board shall design and implement a program, as funding becomes available, including a timetable and procedures for implementation, to progress toward achieving the goal that all children in this state have qualified health care coverage, by maximizing the use of state and private financial support as follows:

a. As funding becomes available, all children who are eligible for medical assistance, Medicaid expansion, and hawk=i shall have coverage by December 31, 2009. Parents of such children shall provide proof that each child has qualified health care coverage at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns or during school registration.

b. As funding becomes available, the state may provide a subsidy to assist with the purchase of qualified health care coverage for the remaining uninsured children up to eighteen years of age using a sliding scale based on family income by December 31, 2009. Parents of such children who are eligible for subsidies shall provide proof that each child has qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns or during school registration.

c. All parents of children up to eighteen years of age may be required to provide proof that each child has qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns or

during school registration.

2. The board shall design and implement a program, including a timetable and procedures for implementation after all children have qualified health care coverage, to work toward achieving the goal that all adults in the state have qualified health care coverage as follows:

a. The state may continue to expand options for individuals who are dually eligible for Medicare and medical assistance by utilizing evidence=based medical treatment.

b. As funding becomes available, the state may provide a subsidy to assist uninsured health and long=term care workers and child care workers with the purchase of qualified health care coverage. The board shall define "health and long=term care workers" and "child care workers" by rule. A health or long=term care worker or child care worker who is eligible for the subsidy shall provide proof of qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns.

c. As funding becomes available, the state may provide a subsidy to assist with the purchase of qualified health care coverage by the remaining uninsured adults using a sliding scale based on income. A person who is eligible for the subsidy shall provide proof of qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns.

d. All adults may be required to provide proof of qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns.

3. An adult or parent of a child who is required to provide proof of qualified health care coverage of the adult or child and does not do so, may automatically be assigned and enrolled in the appropriate coverage offered by the exchange at a cost and in a time and manner determined by the board by rule.

4. The board shall collaborate with carriers to institute health insurance reforms that may become effective before qualified health care coverage for all Iowans has been achieved. Such reforms may include:

a. Carriers may enroll any applicant rated up to two hundred percent of standard premium rates at a maximum premium rate of one hundred fifty percent of the standard premium rate.

b. Any applicant rated at over two hundred percent of standard premium rates may be enrolled in a plan offered by the state, such as the Iowa comprehensive health insurance association or the Iowa health care coverage exchange fund or a combination thereof at one hundred fifty percent of standard premium rates with the state subsidizing any cost over that amount.

c. Carriers may offer open enrollment periods where any applicant may enroll with no preexisting conditions exclusions.

d. Carriers may guarantee issuance of insurance with no preexisting condition exclusions if the applicant was covered by creditable coverage that was continuous to a date not more than sixty=three days prior to the effective date of the new coverage.

DIVISION II
MEDICAL HOME
DIVISION XXI
MEDICAL HOME

Sec. 9. NEW SECTION. 135.154 DEFINITIONS.

As used in this chapter, unless the context otherwise requires:

1. "Department" means the department of public health.

2. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

3. "Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the primary care physician and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health=related services needed by the patient and the patient's family to achieve maximum health

potential; maintains a centralized, comprehensive record of all health=related services to promote continuity of care; and has all of the characteristics specified in section 135.155.

4. "Medical home commission" or "commission" means the medical home commission created in section 135.156.

5. "National committee for quality assurance" means the nationally recognized, independent nonprofit organization that measures the quality and performance of health care and health care plans in the United States; provides accreditation, certification, and recognition programs for health care plans and programs; and is recognized in Iowa as an accrediting organization for commercial and Medicaid=managed care organizations.

6. "Nonphysician primary care professionals" means providers of health care other than physicians who render some primary care services including nurse practitioners, physician assistants, and other health care professionals.

7. "Personal provider" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health needs, and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.

8. "Primary care" means health care which emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified. "Primary care" is usually provided by general and family practitioners, internists, obstetricians, pediatricians, and certain nonprimary care professionals who are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem origin, organ system, or diagnosis. "Primary care" includes health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses. "Primary care" also provides patient advocacy in the health care system to accomplish cost=effective care through coordination of health care services, promotion of effective communication with patients, and encouragement of the role of the patient as a partner in health care.

9. "Primary care physician" means a generalist physician who is specifically trained to provide primary care at the point of first contact, and takes continuing responsibility for providing the patient's care.

Sec. 10. NEW SECTION. 135.155 MEDICAL HOME PURPOSES == CHARACTERISTICS.

1. The purposes of a medical home are the following:

a. To reduce disparities in health care access, delivery, and health care outcomes.

b. To improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage and to provide for the sustainability of the health care system.

c. To provide a tangible method to document if each Iowan has access to health care.

2. A medical home has all of the following characteristics:

a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.

b. A provider=directed medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.

c. Whole person orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end=of=life care.

d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients get the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

e. Quality and safety. The following are quality and

safety components of the medical home:

(1) Provider=directed medical practices advocate for their patients to support the attainment of optimal, patient=centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.

(2) Evidence=based medicine and clinical decision=support tools guide decision making.

(3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient=centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

g. Payment. The payment system appropriately recognizes the added value provided to patients who have a patient=centered medical home. The payment structure framework of the medical home provides all of the following:

(1) Reflects the value of provider and nonprovider staff and patient=centered care management work that is in addition to the face=to=face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of physician work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee=for=service payments for face=to=face visits. Payments for health care management services that are in addition to the face=to=face visit do not result in a reduction in the payments for face=to=face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider=guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

Sec. 11. NEW SECTION. 135.156 MEDICAL HOME COMMISSION.

1. A medical home commission is created consisting of the following members:

a. The director of public health, or the director's designee, who shall act as chairperson of the commission.

b. The director of human services, or the director's designee.

c. The commissioner of insurance, or the commissioner's designee.

d. A representative of health insurers.

e. A representative of the Iowa dental association.

f. A representative of the Iowa nurses association.

g. A family physician who is a member of the Iowa academy of family physicians.

h. A health care consumer.

i. A representative of the Iowa collaborative safety net provider network established pursuant to section 135.153.

2. a. Members of the commission from the organizations specified in subsection 1 shall be selected by the respective organization. Terms of public members of the commission shall begin and end as provided by section 69.19. Any vacancy shall be filled in the same manner as regular appointments are made for the unexpired portion of the regular term. Public members shall serve terms of three years. A member is eligible for

reappointment for two successive terms.

b. Public members of the commission shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

c. The commission shall meet at least quarterly and in accordance with rules adopted by the commission.

d. A majority of the members of the commission constitutes a quorum. Any action taken by the commission must be adopted by the affirmative vote of a majority of its voting membership.

e. The commission is located for administrative purposes within the division of health promotion and chronic disease management within the department. The commission shall coordinate efforts with other divisions, bureaus, and offices within the department including but not limited to the office of multicultural health established in section 135.12 and oral health bureau established in section 135.15, in order to avoid duplication of efforts. The department shall provide office space, staff assistance, administrative support, and necessary supplies and equipment to the commission.

3. The commission may adopt rules pursuant to chapter 17A to administer the programs of the commission.

Sec. 12. NEW SECTION. 135.157 MEDICAL HOME SYSTEM == DEVELOPMENT AND IMPLEMENTATION.

1. The commission shall develop a plan for implementation of a statewide medical home system. The initial phase shall focus on providing a medical home for children, beginning with those children who are recipients of medical assistance or the hawk=i program, and expanding to children covered through the exchange created pursuant to section 514M.4. The second phase shall focus on providing a medical home to the expansion population under the IowaCare program and to adult recipients of medical assistance. The third phase shall focus on providing a medical home to adults covered through the exchange created pursuant to section 514M.4. The commission, in collaboration with parents, schools, communities, health plans, and providers, shall endeavor to increase healthy outcomes for children and adults by linking the children and adults with a medical home, identifying health improvement goals for children and adults, and linking reimbursement strategies to increasing healthy outcomes for children and adults. The plan shall provide that the medical home system shall do all of the following:

a. Coordinate and provide access to evidence=based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well=child health services.

b. Provide access to appropriate specialty care and in=patient services.

c. Provide quality=driven and cost=effective health care.

d. Promote strong and effective medical management including but not limited to planning treatment strategies, monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of service.

e. Emphasize patient and provider accountability.

f. Prioritize local access to the continuum of health care services in the most appropriate setting.

g. Establish a baseline for medical home goals and establish performance measures that indicate a child or adult has an established and effective medical home. For children, these goals and performance measures may include but are not limited to childhood immunizations rates, well=child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and preventive oral health service utilization.

h. For children, coordinate with and integrate guidelines, data, and information from existing newborn and child health programs and entities, including but not limited to the healthy opportunities to experience, success=healthy families Iowa program, the community empowerment program, the center for congenital and inherited disorders screening and health care programs, standards of care for pediatric health guidelines, the office of multicultural health established in section 135.12, the oral health bureau established in section 135.15, and other similar programs and services.

2. The commission shall develop an organizational structure for the medical home system in this state. The organizational structure plan shall integrate existing resources, provide a strategy to coordinate health care

services, provide for monitoring and data collection on medical homes, provide for training and education to health care professionals and families, and provide for transition of children to the adult medical care system. The organizational structure may be based on collaborative teams of stakeholders throughout the state such as local public health agencies, the collaborative safety net provider network established in section 135.153, or a combination of statewide organizations. Care coordination may be provided through regional offices or through individual provider practices. The organizational structure may also include the use of telemedicine resources, and may provide for partnering with pediatric and family practice residency programs to improve access to preventive care for children. The organizational structure shall also address the need to organize and provide health care to increase accessibility for patients including using venues more accessible to patients and having hours of operation that are conducive to the population served.

3. The commission shall adopt standards and a process to certify medical homes based on the national committee for quality assurance standards. The certification process and standards shall provide mechanisms to monitor performance and to evaluate, promote, and improve the quality of health of and health care delivered to patients through a medical home. The mechanism shall require participating providers to monitor clinical progress and performance in meeting applicable standards and to provide information in a form and manner specified by the commission. The evaluation mechanism shall be developed with input from consumers, providers, and payers. At a minimum the evaluation shall determine any increased quality in health care provided and any decrease in cost resulting from the medical home system compared with other health care delivery systems. The standards and process shall also include a mechanism for other ancillary service providers to become affiliated with a certified medical home.

4. The commission shall adopt education and training standards for health care professionals participating in the medical home system.

5. The commission shall provide for system simplification through the use of universal referral forms, internet=based tools for providers, and a central medical home internet site for providers.

6. The commission shall determine a rate of reimbursement and recommend incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In adopting the incentives, the commission shall consider, at a minimum, providing incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the reimbursement system and incentives, the commission shall analyze, at a minimum, the feasibility of all of the following:

a. Reimbursement under the medical assistance program to promote wellness and prevention, provide care coordination, and provide chronic care management.

b. Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations.

c. Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and primary care services.

d. Increased funding for efforts to transform medical practices into certified medical homes, including emphasizing the implementation of the use of electronic health records.

e. Targeted reimbursement to providers linked to health care quality improvement measures established by the commission.

f. Reimbursement for specified ancillary support services such as transportation for medical appointments and other such services.

7. The commission shall coordinate the requirements and activities of the medical home system with the requirements and activities of the dental home for children as described in section 249J.14, subsection 7, and shall recommend financial incentives for dentists and nondental providers to promote oral health care coordination through preventive dental intervention, early identification of oral disease risk, health care coordination and data tracking, treatment, chronic care management, education and training, parental guidance, and oral health promotions for children.

8. The commission shall integrate the recommendations and

policies developed by the prevention and chronic care management advisory council into the medical home system.

9. Implementation phases.

a. Initial implementation shall require participation in the medical home system of children who are recipients of the medical assistance or the hawk=i programs and children who have health insurance coverage through the exchange created in section 514M.4. The commission shall develop an enhanced reimbursement methodology for recipients of medical assistance and hawk=i to compensate providers who participate in the medical home system. The department of human services shall submit any state plan amendments or request any waivers necessary from the centers for Medicare and Medicaid services of the United States department of health and human services for approval of the reimbursement methodology. The commission shall work with the exchange to develop an enhanced reimbursement methodology for children covered through the exchange to compensate providers who participate in the medical home system.

b. The commission shall work with the department of human services and with the exchange to expand the medical home system to adult recipients of medical assistance, the expansion population under the IowaCare program, and adults covered through the exchange. The commission shall work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system.

c. The commission shall work with the department of administrative services to allow state employees to utilize the medical home system.

d. The commission shall work with insurers and self=insured companies, if requested, to make the medical home system available to individuals with private health care coverage.

10. The commission shall provide oversight for all certified medical homes. The commission shall review the progress of the medical home system at each meeting and recommend improvements to the system, as necessary.

11. The commission shall annually evaluate the medical home system and make recommendations to the governor and the general assembly regarding improvements to and continuation of the system.

Sec. 13. Section 249J.14, subsection 7, Code 2007, is amended to read as follows:

7. DENTAL HOME FOR CHILDREN. ~~By July 1, 2008, every~~ Every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental ~~screenings and preventive care identified in the oral health standards~~ services as defined under the early and periodic screening, diagnostic, and treatment program.

DIVISION III

PREVENTION AND CHRONIC CARE MANAGEMENT

DIVISION XXII

PREVENTION AND CHRONIC CARE MANAGEMENT

Sec. 14. NEW SECTION. 135.158 DEFINITIONS.

For the purpose of this division, unless the context otherwise requires:

1. "Chronic care" means health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.

2. "Chronic care information system" means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.

3. "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self=care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence=based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

4. "Chronic care plan" means a plan of care between an

individual and the individual's principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient's own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.

5. "Chronic care resources" means health care professionals, advocacy groups, health departments, schools of public health and medicine, health plans, and others with expertise in public health, health care delivery, health care financing, and health care research.

6. "Chronic condition" means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.

7. "Department" means the department of public health.

8. "Director" means the director of public health.

9. "Eligible individual" means a resident of this state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance or hawk=i, is a member of the expansion population pursuant to chapter 249J, is an inmate of a correctional institution in this state, or is an individual who has qualified health care coverage through the exchange created in section 514M.4.

10. "Health care professional" means health care professional as defined in section 135.154.

11. "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

12. "State initiative for prevention and chronic care management" or "state initiative" means the state's plan for developing a chronic care organizational structure for prevention and chronic care management, including coordinating the efforts of health care professionals and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self=care efforts, providing systemic support for the health care professional=patient relationship and options for channeling chronic care resources and support to health care professionals, providing for community development and outreach and education efforts, and coordinating information technology initiatives with the chronic care information system.

Sec. 15. NEW SECTION. 135.159 PREVENTION AND CHRONIC CARE MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management.

2. The director may accept grants and donations and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative.

3. The director shall establish and convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence=based prevention and chronic care management strategies into the public and private health care systems, including the medical home system. The advisory council, at a minimum, shall include all of the following members:

a. The director of human services, or the director's designee.

b. The director of the department of elder affairs, or the director's designee.

c. The commissioner of insurance, or the commissioner's designee.

d. A representative of the Iowa medical society.

e. A representative of the Iowa hospital association.

f. A representative of health insurers.

g. A medical social worker or home care professional.

h. A patient advocate.

i. A primary care physician.

j. A pharmacist.

k. A specialist in public health and epidemiology.

l. An expert in health outcomes research.

m. A representative of an entity that is taking a leading role in health information technology.

n. A representative of the Iowa college of public health at the university of Iowa.

o. A representative of Des Moines university == osteopathic medical center.

4. a. Members of the advisory council from the organizations specified in subsection 3 shall be selected by the respective organization. Terms of the public members shall begin and end as provided by section 69.19. Any vacancy shall be filled in the same manner as regular appointments are made for the unexpired portion of the regular term. Public members shall serve terms of three years. A public member is eligible for reappointment for two successive terms.

b. Public members shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

c. The advisory council shall meet at least quarterly and in accordance with the rules adopted by the advisory council.

d. A majority of the voting members of the advisory council constitutes a quorum. Any action taken by the advisory council must be adopted by the affirmative vote of a majority of its membership.

e. The advisory council is located for administrative purposes within the division of health promotion and chronic disease management within the department. The department shall provide administrative support to the advisory council.

5. The advisory council shall elicit input from a variety of health care professionals, health care professional organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.

6. The advisory council shall submit initial recommendations to the director for the state initiative for prevention and chronic care management no later than July 1, 2009. The recommendations shall address all of the following:

a. The recommended organizational structure for integrating prevention and chronic care management into the private and public health care systems. The organizational structure recommended shall align with the organizational structure established for the medical home system developed pursuant to division XXI. The advisory council shall also review existing prevention and chronic care management strategies used in the health insurance market and in private and public programs and recommend ways to expand the use of such strategies throughout the health insurance market and in the private and public health care systems.

b. A process for identifying leading health care professionals and existing prevention and chronic care management programs in the state, and coordinating care among these health care professionals and programs.

c. A prioritization of the chronic conditions for which prevention and chronic care management services should be provided, taking into consideration the prevalence of specific chronic conditions and the factors that may lead to the development of chronic conditions; the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals; the availability of workable, evidence=based approaches to chronic care for the chronic condition; and public input into the selection process. The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and shall also specify a timeline for inclusion of additional specific chronic conditions in the initiative.

d. A method to involve health care professionals in identifying eligible patients for prevention and chronic care management services, which includes but is not limited to the use of a uniform health risk assessment.

e. The methods for increasing communication between health care professionals and patients, including patient education, patient self=management, and patient follow=up plans.

f. The educational, wellness, and clinical management protocols and tools to be used by health care professionals, including management guideline materials for health care delivery.

g. The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks such as the best in class

estimates utilized in the national healthcare quality report of the agency for health care research and quality of the United States department of health and human services, to provide performance feedback for health care professionals and information on the quality of health care, including patient satisfaction and health status outcomes.

h. Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of health care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

i. Methods to involve public and private groups, health care professionals, insurers, third=party administrators, associations, community and consumer groups, and other entities to facilitate and sustain the initiative.

j. Alignment of any chronic care information system or other information technology needs with other health care information technology initiatives.

k. Involvement of appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

l. Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care professionals, health insurers, and the public.

m. A method to periodically determine the percentage of health care professionals who are participating, the success of the empowerment=of=patients approach, and any results of health outcomes of the patients participating.

n. A means of collaborating with the bureau of professional licensure within the department to review prevention and chronic care management education provided to licensees, as appropriate, and recommendations regarding education resources and curricula for integration into existing and new education and training programs.

6. The director of human services shall obtain any federal waivers or state plan amendments necessary to implement the prevention and chronic care management initiative within the medical assistance, hawk=i, and IowaCare populations.

7. Following submission of the initial recommendations by January 1, 2009, and initial implementation among the population of eligible individuals, the director shall work with the department of human services, insurers, health care professional organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in this state. The advisory council shall continue to review and make recommendations to the director regarding improvements in the initiative.

Sec. 16. NEW SECTION. 8A.440 PREVENTION AND CHRONIC CARE MANAGEMENT == HEALTH BENEFIT PLAN.

The department shall include in any request for proposals for the administration of the health benefit plans for state employees a request for a description of any prevention and chronic care management program provided by the entity offering the health benefit plan. The department shall also work with the department of public health regarding how and when to align the state employees' health benefit plan with the provisions developed for the prevention and chronic care management initiative created in chapter 135, division XXII.

DIVISION IV
IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

Sec. 17. NEW SECTION. 8.70 DEFINITIONS.

As used in this division, unless the context otherwise requires:

1. "Health care professional" means health care professional as defined in section 135.154.

2. "Health information technology" means the application of information processing, involving both computer hardware and software, that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication, decision making, quality, safety, and efficiency of clinical practice, and may include but is not limited to:

a. An electronic health record that electronically

compiles and maintains health information that may be derived from multiple sources about the health status of an individual and may include a core subset of each care delivery organization's electronic medical record such as a continuity of care record or a continuity of care document, computerized physician order entry, electronic prescribing, or clinical decision support.

b. A personal health record through which an individual and any other person authorized by the individual can maintain and manage the individual's health information.

c. An electronic medical record that is used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery organization, is the legal record of the patient's encounter with the care delivery organization, and is owned by the care delivery organization.

d. A computerized provider order entry function that permits the electronic ordering of diagnostic and treatment services, including prescription drugs.

e. A decision support function to assist physicians and other health care providers in making clinical decisions by providing electronic alerts and reminders to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments.

f. An error notification function that generates a warning when an order is entered that is likely to lead to a significant adverse outcome for individuals.

g. Tools to allow for the collection, analysis, and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction, and other health care=related performance measures.

3. "Interoperability" means the ability of two or more systems or components to exchange information or data in an accurate, effective, secure, and consistent manner and to use the information or data that has been exchanged and includes but is not limited to:

a. The capacity to connect to a network for the purpose of exchanging information or data with other users.

b. The ability of a connected, authenticated user to demonstrate appropriate permissions to participate in the instant transaction over the network.

c. The capacity of a connected, authenticated user to access, transmit, receive, and exchange usable information with other users.

4. "Recognized interoperability standard" means interoperability standards recognized by the office of the national coordinator for health information technology of the United States department of health and human services.

Sec. 18. NEW SECTION. 8.71 IOWA ELECTRONIC HEALTH == PRINCIPLES == GOALS.

1. Health information technology is rapidly evolving so that it can contribute to the goal of improving access to and quality of health care, enhancing efficiency, and reducing costs.

2. To be effective, the health information technology system shall comply with all of the following principles:

a. Be patient=centered and market=driven.

b. Be based on approved standards developed with input from all stakeholders.

c. Protect the privacy of consumers and the security and confidentiality of all health information.

d. Promote interoperability.

e. Ensure the accuracy, completeness, and uniformity of data.

3. Widespread adoption of health information technology is critical to a successful health information technology system and is best achieved when all of the following occur:

a. The market provides a variety of certified products from which to choose in order to best fit the needs of the user.

b. The system provides incentives for health care professionals to utilize the health information technology and provides rewards for any improvement in quality and efficiency resulting from such utilization.

c. The system provides protocols to address critical problems.

d. The system is financed by all who benefit from the improved quality, efficiency, savings, and other benefits that result from use of health information technology.

Sec. 19. NEW SECTION. 8.72 IOWA ELECTRONIC HEALTH

INFORMATION COMMISSION.

1. a. An electronic health information commission is created as a public and private collaborative effort to promote the adoption and use of health information technology in this state in order to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals with comprehensive, real=time medical information to provide continuity of care and make the best health care decisions. The commission shall provide oversight for the development, implementation, and coordination of an interoperable electronic health records system, telehealth expansion efforts, the health information technology infrastructure, and other health information technology initiatives in this state.

b. All health information technology efforts shall endeavor to represent the interests and meet the needs of consumers and the health care sector, protect the privacy of individuals and the confidentiality of individuals' information, promote physician best practices, and make information easily accessible to the appropriate parties. The system developed shall be consumer=driven, flexible, and expandable.

2. The commission shall consist of the following voting members:

a. Individuals with broad experience and vision in health care and health technology and one member representing the health care consumer. The voting members shall be appointed by the governor, subject to confirmation by the senate. The voting members shall include all of the following:

(1) The director of the Iowa communications network.

(2) Two members who are the chief information officers of the two largest private health care systems.

(3) One member who is the chief information officer of a public health care system.

(4) A representative of the private telecommunications industry.

(5) A representative of a rural hospital that is a member of the Iowa hospital association.

(6) A consumer advocate.

(7) A representative of the Iowa safety net provider network created in section 135.153.

3. a. The members shall select a chairperson, annually, from among the membership, and shall serve terms of three years beginning and ending as provided in section 69.19. Voting member appointments shall comply with sections 69.16 and 69.16A. Vacancies shall be filled by the original appointing authority and in the manner of the original appointments. Members shall receive reimbursement for actual expenses incurred while serving in their official capacity and voting members may also be eligible to receive compensation as provided in section 7E.6. A person appointed to fill a vacancy for a member shall serve only for the unexpired portion of the term. A member is eligible for reappointment for two successive terms.

b. The commission shall meet at the call of the chairperson. A majority of the voting members of the commission constitutes a quorum. Any action taken by the commission must be adopted by the affirmative vote of a majority of its voting membership.

c. The commission is located for administrative purposes within the department of management. The department shall provide office space, staff assistance, administrative support, and necessary supplies and equipment for the commission.

4. The commission shall do all of the following:

a. Establish an advisory council which shall consist of the representatives of entities involved in the electronic health records system task force established pursuant to section 217.41A, Code 2007, and any other members the commission determines necessary to assist in the commission's duties including but not limited to consumers and consumer advocacy organizations; physicians and health care professionals; leadership of community hospitals and major integrated health care delivery networks; state agencies including the department of public health, the department of human services, the department of elder affairs, the division of insurance of the department of commerce, and the office of the attorney general; health plans and health insurers; legal experts; academics and ethicists; business leaders; and professional associations.

b. Adopt a statewide health information technology plan by January 1, 2009. In developing the plan, the commission shall seek the input of providers, payers, and consumers. Standards and policies developed for the plan shall promote and be consistent with national standards developed by the office of the national coordinator for health information technology of the United States department of health and human services and shall address or provide for all of the following:

(1) The effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvement. The commission shall adopt requirements for interoperable electronic health records in this state including a recognized interoperability standard.

(2) Education of the public and health care sector about the value of health information technology in improving patient care, and methods to promote increased support and collaboration of state and local public health agencies, health care professionals, and consumers in health information technology initiatives.

(3) Uniform standards for the exchange of health care information and interoperable electronic health records.

(4) Policies relating to the protection of privacy of patients and the security and confidentiality of patient information.

(5) Policies relating to information ownership.

(6) Policies relating to governance of the various facets of the health information technology system.

(7) A single patient identifier to share secure patient information. All health care professionals shall utilize the single patient identifier by January 1, 2010.

(8) A standard continuity of care record and other issues related to the content of electronic transmissions. All health care professionals shall utilize the standard continuity of care record by January 1, 2010.

(9) Requirements for electronic prescribing.

(10) Economic incentives and support to facilitate participation in an interoperable system by health care professionals.

c. Identify existing and potential health information technology efforts in this state, regionally, and nationally, and integrate existing efforts to avoid incompatibility between efforts and avoid duplication.

d. Coordinate public and private efforts to provide the network backbone infrastructure for the health information technology system. In coordinating these efforts, the commission shall do all of the following:

(1) Adopt policies to effectuate the logical cost effective usage of and access to the state=owned network, and support of telecommunication carrier products, where applicable.

(2) Complete a memorandum of understanding by January 1, 2009, with the Iowa communications network for governmental access usage, with private fiber optic networks for core backbone usage of private fiber optic networks, and with any other communications entity for state=subsidized usage of the communications entity's products to access any backbone network.

(3) Establish protocols to ensure compliance with any applicable federal standards.

(4) Determine costs for accessing the network at a level that provides sufficient funding for the network.

e. Promote the use of telemedicine.

(1) Examine existing barriers to the use of telemedicine and make recommendations for eliminating these barriers.

(2) Examine the most efficient and effective systems of technology for use and make recommendations based on the findings.

f. Address the workforce needs generated by increased use of health information technology.

g. Adopt rules in accordance with chapter 17A to implement all aspects of the statewide plan and the network.

h. Coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in this state.

i. Seek and apply for any federal or private funding to assist in the implementation and support of the health information technology system and make recommendations for funding mechanisms for the ongoing development and maintenance costs of the health information technology system.

j. Identify state laws and rules that present barriers to

the development of the health information technology system and recommend any changes to the governor and the general assembly.

Sec. 20. Section 217.41A, Code 2007, is repealed.

DIVISION V

LONG=TERM CARE PLANNING AND ADVANCE MEDICAL DIRECTIVES

Sec. 21. Section 144A.11, Code 2007, is amended by adding the following new subsections:

NEW SUBSECTION. 7. A hospital or health care provider shall establish a nonjudicial means of resolving disputes arising out of a disagreement over compliance with a declaration or out=of=hospital do=not=resuscitate order.

NEW SUBSECTION. 8. A hospital or health care provider shall utilize the physician orders for life=sustaining treatment form reflecting the declaration of a patient and shall ensure that the form accompanies any patient who is comatose, incompetent, or otherwise physically or mentally incapable of communication if the patient is transferred to another facility. The department shall create a standardized physician orders for life=sustaining treatment form to be used by hospitals and other health care providers in this state and shall adopt rules for the use of the form.

Sec. 22. Section 144B.12, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 5. A health care provider shall establish a nonjudicial means of resolving disputes arising out of a disagreement over compliance with a durable power of attorney for health care.

Sec. 23. NEW SECTION. 147.28B PALLIATIVE CARE == PROMOTION.

1. For the purposes of this section, "palliative care" means the active total care of patients whose prognosis is limited due to progressive, advanced disease. The purpose of such care is to alleviate pain and other distressing symptoms, and to enhance the quality of life, not to hasten or postpone death.

2. The board of medicine, the board of nursing, and other boards for whom palliative care is within the profession's scope of practice shall do all of the following:

a. Develop and advance scientific understanding of palliative care.

b. Collect and disseminate protocols and evidence=based practices regarding palliative care, with priority given to pain management for terminally ill patients, and make such information available to public and private health care programs and providers, medical or other health professional schools, hospice organizations, and the general public.

3. The board of medicine, the board of nursing, and other boards for whom palliative care is within the profession's scope of practice shall work with medical or other health professional schools, residency training programs and other graduate programs in the health professions, entities providing continuing medical education, hospices, and other appropriate programs and entities to include in the curriculum information and education on the use of palliative care.

Sec. 24. NEW SECTION. 514C.23 HOSPICE CARE COVERAGE.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy or contract providing for third=party payment or prepayment of health or medical expenses shall provide coverage benefits for the costs associated with the provision of core services, as defined in section 135J.1, provided by a licensed hospice program.

2. a. This section applies to the following classes of third=party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2008:

(1) Individual or group accident and sickness insurance providing coverage on an expense=incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to chapter 509A for public employees.

(6) An organized delivery system licensed by the director of public health.

b. This section shall not apply to accident=only, specified disease, short=term hospital or medical, hospital

confinement indemnity, credit, dental, vision, Medicare supplement, long=term care, basic hospital and medical=surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical= payment insurance.

Sec. 25. LONG=TERM LIVING PLANNING TOOLS == PUBLIC EDUCATION CAMPAIGN. The legal services development and substitute decision maker programs of the department of elder affairs, in collaboration with other appropriate agencies and interested parties, shall research existing long=term living planning tools that are designed to increase quality of life and contain health care costs and recommend a public education campaign strategy on long=term living to the general assembly by January 1, 2009.

Sec. 26. LONG=TERM CARE OPTIONS PUBLIC EDUCATION CAMPAIGN. The department of elder affairs, in collaboration with the insurance division of the department of commerce, shall implement a long=term care options public education campaign. The campaign may utilize such tools as the "Own Your Future Planning Kit" administered by the centers for Medicare and Medicaid services, the administration on aging, and the office of the assistant secretary for planning and evaluation of the United States department of health and human services, and other tools developed through the aging and disability resource center program of the administration on aging and the centers for Medicare and Medicaid services designed to promote health and independence as Iowans age, assist older Iowans in making informed choices about the availability of long=term care options, including alternatives to facility=based care, and to streamline access to long=term care.

Sec. 27. HOME AND COMMUNITY=BASED SERVICES PUBLIC EDUCATION CAMPAIGN. The department of elder affairs shall work with other public and private agencies to identify resources that may be used to continue the work of the aging and disability resource center established by the department through the aging and disability resource center grant program efforts of the administration on aging and the centers for Medicare and Medicaid services of the United States department of health and human services, beyond the federal grant period ending September 30, 2008.

DIVISION VI

DIVISION OF HEALTH CARE QUALITY, CONSUMER INFORMATION, STRATEGIC PLANNING, AND RESOURCE DEVELOPMENT

DIVISION V

DIVISION OF HEALTH CARE QUALITY, CONSUMER INFORMATION, STRATEGIC PLANNING, AND RESOURCE DEVELOPMENT

Sec. 28. NEW SECTION. 135.45 DIVISION OF HEALTH CARE QUALITY, CONSUMER INFORMATION, STRATEGIC PLANNING, AND RESOURCE DEVELOPMENT.

A division of health care quality, consumer information, strategic planning, and resource development is created in the department of public health. The division shall include, at a minimum, the following bureaus:

1. The bureau of health care quality and consumer information.

2. The bureau of health care strategic planning and resource development.

BUREAU OF HEALTH CARE QUALITY AND CONSUMER INFORMATION

Sec. 29. NEW SECTION. 135.46 BUREAU OF HEALTH CARE QUALITY AND CONSUMER INFORMATION == DUTIES.

A bureau of health care quality and consumer information is created to provide better coordination of health care delivery information to improve the public health, inform policy analysis, and provide transparency of consumer health information. The bureau, at a minimum, shall do all of the following:

1. Develop data collection requirements, collect data, and administer an internet=based consumer guide to health care relating to price, quality, safety, and other aspects of the health care delivery system to promote quality care that is safe, effective, patient=centered, timely, efficient, and equitable, and to empower individuals to make economically sound and medically appropriate decisions regarding their personal health.

2. Develop and implement cost=containment measures that help to contain costs while improving quality in the health care system.

3. Provide for coordination of public and private cost=containment, quality, and safety efforts in this state.

4. Carry out other health care price, quality, and safety=related research as directed by the governor and the general assembly.

Sec. 30. NEW SECTION. 135.47 IOWA HEALTH QUALITY AND COST=CONTAINMENT COLLABORATIVE.

1. The bureau shall convene an Iowa health quality and cost=containment collaborative to develop a process and the infrastructure to provide price, quality, safety, and other appropriate information to consumers. The collaborative shall include but is not limited to all of the following members:

a. The director of public health, or the director's designee, who shall serve as chairperson of the collaborative.

b. A representative of the university of Iowa college of public health.

c. A representative of Des Moines university=osteopathic medical center.

d. A representative of health care consumers.

e. The president of the Iowa healthcare collaborative.

f. A representative of the Iowa health buyers' alliance.

g. A representative of the long=term care industry.

2. The department of public health shall provide administrative support to the collaborative. Public members shall receive reimbursement for actual expenses incurred while engaged in the performance of official duties.

3. The collaborative shall review efforts of other states, the federal government, and private entities to identify meaningful tools to measure prices, safety, and the delivery of quality care, determine specific information and a format for publishing the information that is most useful to the consumer including contextual information and explanations that the public can easily understand, and to identify cost=containment strategies that also result in improved health care quality. Following the collaborative's review, the collaborative shall do all of the following:

a. Facilitate the disclosure of price, quality, and safety information by supporting and expanding existing public and private efforts and by identifying and recommending ways to eliminate barriers to such disclosure.

b. Develop for implementation by July 1, 2009, a method for hospitals, health care providers, long=term care providers, insurers, and health care plans to collaborate in providing consumers with the usual and customary charges for a specified health service and specifically what the charges include and the factors that may cause the charges to vary, a good faith estimate of the actual billed charge and the amount for which the consumer may be personally liable for a specified health care service based on a consumer's specific health care coverage, and, if the consumer does not have health care coverage, providing a good faith estimate of the average allowable reimbursement the provider accepts as payment from such private third=party payers for the service specified and the estimated amount for which the noncovered consumer would be personally liable to pay.

c. Develop for implementation by July 1, 2010, requirements for the identification, collection, standardization, sharing, and public disclosure of pricing, quality, and patient safety data from hospitals and health care providers in this state.

d. Develop for implementation by July 1, 2009, uniform billing practices including uniform claim forms, billing codes, and compatible electronic or other data interchange standards for use by health care providers and payers in their health care claims, health care encounters, and electronic or other data interchange activities.

e. Develop and direct the department of human services to utilize quality and safety standards as a basis for increased provider reimbursement under the medical assistance, hawk=i, and IowaCare programs.

f. Develop cost=containment strategies. Cost containment strategies may include but are not limited to modification of health care reimbursement methodologies to reward quality, incorporate evidence=based standards and promote best practices, to direct individuals into quality health care delivery, to encourage primary care, and to utilize telemedicine and health information technology.

g. Establish a health and wellness strategies consortium to act as a catalyst in advancing voluntarily adopted strategies to improve quality of care, increase access to services, reduce disparities in health care delivery and contain costs while emphasizing population health and wellness. The core membership of the consortium shall include

representatives of health care purchasers, payers, and providers. The consortium shall direct strategies for health care payers and providers to adopt which may include but are not limited to:

(1) Strategies to promote wellness which may include:

(a) Providing smoking cessation programs as a standard health care benefit including reimbursement for treatment and support services.

(b) Providing obesity prevention services as a standard health care benefit.

(c) Increasing immunization rates for pneumococcal and influenza which may include approving an administration fee for all qualified providers of influenza and pneumococcal vaccinations.

(d) Providing health care benefit incentives for consumers who participate in wellness programs.

(e) Assuring that health care coverage for children includes primary, preventive, and developmental health services.

(2) Strategies to contain health care costs which may include:

(a) Promoting adoption of health information technology through provider incentives.

(b) Considering a four=tier prescription drug copayment system within a prescription drug benefit that includes a zero copayment tier for select medications to improve patient compliance.

(c) Providing a standard medication therapy management program as a prescription drug benefit to optimize high=risk patient's medication outcomes.

(d) Investigating whether pooled purchasing for prescription drug benefits, such as a common statewide preferred drug list, would decrease costs.

(3) Strategies to increase the public's role and responsibility in personal health care choices and decisions which may include:

(a) Creating a public awareness campaign to educate consumers on smart health care choices and promoting value= based purchasing.

(b) Promoting public reporting of quality and performance measures that support a value=based purchasing system.

(4) Implementation strategies which may include piloting the various wellness, cost=containment, and public involvement strategies utilizing publicly funded health care coverage groups such as the medical assistance program, state of Iowa employee group health plans, and regents institutions health care plans, consistent with collective bargaining agreements in effect.

h. Identify the process and time frames for implementation of any initiatives, identify any barriers to implementation of initiatives, and recommend any changes in law or rules necessary to eliminate the barriers and implement the initiatives.

Sec. 31. NEW SECTION. 135.48 ESTIMATE OF CHARGES.

A health care provider, including a hospital, prior to provision of medical services, shall provide a patient, upon request, a reasonable estimate of charges for such services. The information provided shall explain the methodology in determining the estimate and shall state that the estimate does not preclude the health care provider from exceeding the estimate or making additional charges based on changes in the patient's condition, treatment needs, or third=party payer requirements. The department shall develop a form to be used by a health care provider, including a hospital, in providing the information required by this section. For the purposes of this section, "health care provider" means "health care professional" as defined in section 135.154.

BUREAU OF HEALTH CARE STRATEGIC PLANNING AND RESOURCE DEVELOPMENT

Sec. 32. NEW SECTION. 135.49 BUREAU OF HEALTH CARE STRATEGIC PLANNING AND RESOURCE DEVELOPMENT.

A bureau of health care strategic planning and resource development is created to coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well=qualified, diverse, and sustainable health care workforce in this state. The bureau shall, at a minimum, do all of the following:

1. Develop a strategic plan for health care delivery infrastructure and health care workforce resources in this state.

2. Provide for the continuous collection of data to

provide a basis for health care strategic planning and health care policymaking.

3. Make recommendations regarding the health care delivery infrastructure and the workforce that assist in monitoring current needs, predicting future trends, and informing policymaking.

4. Administer the certificate of need program and provide support to the health care strategic planning council established in section 135.62.

Sec. 33. NEW SECTION. 135.50 STRATEGIC PLAN.

1. The strategic plan for health care delivery infrastructure and health care workforce resources shall describe the existing health care system, describe and provide a rationale for the desired health care system, provide an action plan for implementation, and provide methods to evaluate the system. The plan shall incorporate expenditure control methods and integrate criteria for evidence=based health care. The bureau of health care strategic planning and resource development shall do all of the following in developing the strategic plan for health care delivery infrastructure and health care workforce resources:

a. Conduct strategic health planning activities related to preparation of the strategic plan.

b. Develop a computerized system for accessing, analyzing, and disseminating data relevant to strategic health planning. The bureau may enter into data sharing agreements and contractual arrangements necessary to obtain or disseminate relevant data.

c. Conduct research and analysis or arrange for research and analysis projects to be conducted by public or private organizations to further the development of the strategic plan.

d. Establish a technical advisory committee to assist in the development of the strategic plan. The members of the committee may include but are not limited to health economists, health planners, representatives of health care purchasers, representatives of state and local agencies that regulate entities involved in health care, representatives of health care providers and health care facilities, and consumers.

2. The strategic plan shall include statewide health planning policies and goals related to the availability of health care facilities and services, the quality of care, and the cost of care. The policies and goals shall be based on the following principles:

a. That a strategic health planning process, responsive to changing health and social needs and conditions, is essential to the health, safety, and welfare of Iowans. The process shall be reviewed and updated as necessary to ensure that the strategic plan addresses all of the following:

(1) Promoting and maintaining the health of all Iowans.

(2) Providing accessible health care services through the maintenance of an adequate supply of health facilities and an adequate workforce.

(3) Controlling excessive increases in costs.

(4) Applying specific quality criteria and population health indicators.

(5) Recognizing prevention and wellness as priorities in health care programs to improve quality and reduce costs.

(6) Addressing periodic priority issues including disaster planning, public health threats, and public safety dilemmas.

(7) Coordinating health care delivery and resource development efforts among state agencies including those tasked with facility, services, and professional provider licensure; state and federal reimbursement; health service utilization data systems; and others.

b. That both consumers and providers throughout the state must be involved in the health planning process, outcomes of which shall be clearly articulated and available for public review and use.

c. That the supply of a health care service has a substantial impact on utilization of the service, independent of the effectiveness, medical necessity, or appropriateness of the particular health care service for a particular individual.

d. That given that health care resources are not unlimited, the impact of any new health care service or facility on overall health expenditures in this state must be considered.

e. That excess capacity of health care services and facilities places an increased economic burden on the public.

f. That the likelihood that a requested new health care facility, service, or equipment will improve health care quality and outcomes must be considered.

g. That development and ongoing maintenance of current and accurate health care information and statistics related to cost and quality of health care and projections of the need for health care facilities and services are necessary to developing an effective health care planning strategy.

h. That the certificate of need program as a component of the health care planning regulatory process must balance considerations of access to quality care at a reasonable cost for all Iowans, optimal use of existing health care resources, fostering of expenditure control, and elimination of unnecessary duplication of health care facilities and services, while supporting improved health care outcomes.

i. That strategic health care planning must be concerned with the stability of the health care system, encompassing health care financing, quality, and the availability of information and services for all residents.

3. The health care delivery infrastructure and resources strategic plan developed by the bureau shall include all of the following:

a. A health care system assessment and objectives component that does all of the following:

(1) Describes state and regional population demographics, health status indicators, and trends in health status and health care needs.

(2) Identifies key policy objectives for the state health care system related to access to care, health care outcomes, quality, and cost=effectiveness.

b. A health care facilities and services plan that assesses the demand for health care facilities and services to inform state health care planning efforts and direct certificate of need determinations, for those facilities and services subject to certificate of need. The plan shall include all of the following:

(1) An inventory of each geographic region's existing health care facilities and services.

(2) Projections of the need for each category of health care facility and service, including those subject to certificate of need.

(3) Policies to guide the addition of new or expanded health care facilities and services to promote the use of quality, evidence=based, cost=effective health care delivery options, including any recommendations for criteria, standards, and methods relevant to the certificate of need review process.

(4) An assessment of the availability of health care providers, public health resources, transportation infrastructure, and other considerations necessary to support the needed health care facilities and services in each region.

c. (1) A health care data resources plan that identifies data elements necessary to properly conduct planning activities and to review certificate of need applications, including data related to inpatient and outpatient utilization and outcomes information, and financial and utilization information related to charity care, quality, and cost.

(2) The plan shall inventory existing data resources, both public and private, that store and disclose information relevant to the health care planning process, including information necessary to conduct certificate of need activities. The plan shall identify any deficiencies in the inventory of existing data resources and the data necessary to conduct comprehensive health care planning activities. The plan may recommend that the bureau be authorized to access existing data sources and conduct appropriate analyses of such data or that other agencies expand their data collection activities as statutory authority permits. The plan may identify any computing infrastructure deficiencies that impede the proper storage, transmission, and analysis of health care planning data.

(3) The plan shall provide recommendations for increasing the availability of data related to health care planning to provide greater community involvement in the health care planning process and consistency in data used for certificate of need applications and determinations. The plan shall also integrate the requirements for annual reports by hospitals and health care facilities pursuant to section 135.75, the provisions relating to analyses and studies by the department pursuant to section 135.76, the data compilation provisions of section 135.78, and the provisions for contracts for

assistance with analyses, studies, and data pursuant to section 135.83.

d. An assessment of emerging trends in health care delivery and technology as they relate to access to health care facilities and services, quality of care, and costs of care. The assessment shall recommend any changes to the scope of health care facilities and services covered by the certificate of need program that may be warranted by these emerging trends. In addition, the assessment may recommend any changes to criteria used by the department to review certificate of need applications, as necessary.

e. A rural health resources plan to assess the availability of health resources in rural areas of the state, assess the unmet needs of these communities, and evaluate how federal and state reimbursement policies can be modified, if necessary, to more efficiently and effectively meet the health care needs of rural communities. The plan shall consider the unique health care needs of rural communities, the adequacy of the rural health workforce, and transportation needs for accessing appropriate care.

f. A health care workforce resources plan to assure a competent, diverse, and sustainable health care workforce in Iowa and to improve access to health care in underserved areas and among underserved populations. The plan shall include the establishment of an advisory council to inform and advise the bureau, the department, and policymakers regarding issues relevant to the health care workforce in Iowa.

4. The bureau shall submit the initial statewide health care delivery infrastructure and resources strategic plan to the governor and the general assembly by January 1, 2010, and shall submit an updated strategic plan to the governor and the general assembly every two years thereafter.

DIVISION VII
CERTIFICATE OF NEED PROGRAM

Sec. 34. Section 68B.35, subsection 2, paragraph e, Code 2007, is amended to read as follows:

e. Members of the state banking council, the ethics and campaign disclosure board, the credit union review board, the economic development board, the employment appeal board, the environmental protection commission, the health ~~facilities~~ care strategic planning council, the Iowa finance authority, the Iowa public employees' retirement system investment board, the board of the Iowa lottery authority, the natural resource commission, the board of parole, the petroleum underground storage tank fund board, the public employment relations board, the state racing and gaming commission, the state board of regents, the tax review board, the transportation commission, the office of consumer advocate, the utilities board, the Iowa telecommunications and technology commission, and any full=time members of other boards and commissions as defined under section 7E.4 who receive an annual salary for their service on the board or commission. The Iowa ethics and campaign disclosure board shall conduct an annual review to determine if members of any other board, commission, or authority should file a statement and shall require the filing of a statement pursuant to rules adopted pursuant to chapter 17A.

Sec. 35. Section 97B.1A, subsection 8, paragraph a, subparagraph (8), Code 2007, is amended to read as follows:

(8) Members of the state transportation commission, the board of parole, and the ~~state~~ health ~~facilities~~ care strategic planning council.

Sec. 36. Section 135.61, subsection 1, paragraph d, code 2007, is amended to read as follows:

d. Each institutional health facility or health maintenance organization which, prior to receipt of the application by the ~~department~~ bureau, has formally indicated to the ~~department~~ bureau pursuant to this division an intent to furnish in the future institutional health services similar to the new institutional health service proposed in the application.

Sec. 37. Section 135.61, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. "Bureau" means the bureau of health care strategic planning and resource development created pursuant to section 135.49.

Sec. 38. Section 135.61, subsection 4, Code 2007, is amended to read as follows:

4. "Council" means the ~~state~~ health ~~facilities~~ care strategic planning council established by this division.

Sec. 39. Section 135.61, subsection 18, paragraph d, Code

2007, is amended to read as follows:

d. A permanent change in the bed capacity, as determined by the ~~department~~ bureau, of an institutional health facility. For purposes of this paragraph, a change is permanent if it is intended to be effective for one year or more.

Sec. 40. NEW SECTION. 135.61A PURPOSES OF CERTIFICATE OF NEED PROGRAM.

The purposes of the certificate of need program are to facilitate access to quality care at a reasonable cost for all Iowans, to encourage optimal use of existing health care resources, to foster expenditure control, to support quality improvement efforts, and to prevent unnecessary duplication of institutional health facilities, health services, and health care equipment. In order to determine if the program is complying with the purposes established, regular evaluation of the impact of the certificate of need program on health care expenditures, access, quality, and innovation must exist.

Sec. 41. Section 135.62, Code 2007, is amended to read as follows:

135.62 ~~DEPARTMENT~~ BUREAU TO ADMINISTER DIVISION == HEALTH ~~FACILITIES~~ CARE STRATEGIC PLANNING COUNCIL ESTABLISHED == APPOINTMENTS == POWERS AND DUTIES.

1. This division shall be administered by the ~~department~~ bureau. The director shall employ or cause to be employed the necessary persons to discharge the duties imposed on the ~~department~~ bureau by this division.

2. There is established a ~~state~~ health ~~facilities~~ care strategic planning council consisting of ~~five~~ seven persons appointed by the governor, one of whom shall be a health economist, one of whom shall be an actuary, and at least one of whom shall be a health care consumer. The council shall be within the ~~department~~ bureau for administrative and budgetary purposes.

a. QUALIFICATIONS. The members of the council shall be chosen so that the council as a whole is broadly representative of various geographical areas of the state, and no more than ~~three~~ four of its members are affiliated with the same political party. Each council member shall be a person who has demonstrated by prior activities an informed concern for the planning and delivery of health services. No member of the council, nor any spouse of a member, shall during the time that member is serving on the council meet either of the following prohibitions:

(1) Be a health care provider, ~~nor~~ be otherwise directly or indirectly engaged in the delivery of health care services ~~nor~~, or have a material financial interest in the providing or delivery of health services~~; nor~~.

(2) Serve as a member of any board or other policymaking or advisory body of an institutional health facility, a health maintenance organization, or any health or hospital insurer.

b. APPOINTMENTS. Terms of council members shall be six years, beginning and ending as provided in section 69.19. A member shall be appointed in each odd=numbered year to succeed each member whose term expires in that year. Vacancies shall be filled by the governor for the balance of the unexpired term. Each appointment to the council is subject to confirmation by the senate. A council member is ineligible for appointment to a second consecutive term, unless first appointed to an unexpired term of three years or less.

The governor shall designate one of the council members as chairperson. That designation may be changed not later than July 1 of any odd=numbered year, effective on the date of the organizational meeting held in that year under paragraph "c" ~~of this subsection~~.

c. MEETINGS. The council shall hold an organizational meeting in July of each odd=numbered year, or as soon thereafter as the new appointee or appointees are confirmed and have qualified. Other meetings shall be held as necessary to enable the council to expeditiously discharge its duties. Meeting dates shall be set upon adjournment or by call of the chairperson upon five days' notice to the other members. Each member of the council shall receive a per diem as specified in section 7E.6 and reimbursement for actual expenses while engaged in official duties.

d. DUTIES. The council shall:

(1) Make the final decision, as required by section 135.69, with respect to each application for a certificate of need accepted by the ~~department~~ bureau.

(2) Determine and adopt such policies as are authorized by law and are deemed necessary to the efficient discharge of its duties under this division.

(3) Have authority to direct staff personnel of the department or bureau assigned to conduct formal or summary reviews of applications for certificates of need.

(4) Advise and counsel with the director or administrator concerning the provisions of this division, and the policies and procedures adopted by the department or bureau pursuant to this division.

(5) Review and approve, prior to promulgation, all rules adopted by the department under this division.

Sec. 42. Section 135.63, subsection 1, Code 2007, is amended to read as follows:

1. A new institutional health service or changed institutional health service shall not be offered or developed in this state without prior application to the ~~department~~ bureau for and receipt of a certificate of need, pursuant to this division. The application shall be made upon forms furnished or prescribed by the department or bureau and shall contain such information as the department or bureau may require under this division. The application shall be accompanied by a fee equivalent to three=tenths of one percent of the anticipated cost of the project with a minimum fee of six hundred dollars and a maximum fee of twenty=one thousand dollars. The fee shall be remitted by the department or bureau to the treasurer of state, who shall place it in the general fund of the state. If an application is voluntarily withdrawn within thirty calendar days after submission, seventy=five percent of the application fee shall be refunded; if the application is voluntarily withdrawn more than thirty but within sixty days after submission, fifty percent of the application fee shall be refunded; if the application is withdrawn voluntarily more than sixty days after submission, twenty=five percent of the application fee shall be refunded. Notwithstanding the required payment of an application fee under this subsection, an applicant for a new institutional health service or a changed institutional health service offered or developed by an intermediate care facility for persons with mental retardation or an intermediate care facility for persons with mental illness as defined pursuant to section 135C.1 is exempt from payment of the application fee.

Sec. 43. Section 135.63, subsection 2, paragraphs g, h, k, l, and p, Code 2007, are amended to read as follows:

g. A reduction in bed capacity of an institutional health facility, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:

(1) The institutional health facility reports to the ~~department~~ bureau the number and type of beds reduced on a form prescribed by the department or bureau at least thirty days before the reduction. In the case of a health care facility, the new bed total must be consistent with the number of licensed beds at the facility. In the case of a hospital, the number of beds must be consistent with bed totals reported to the department of inspections and appeals for purposes of licensure and certification.

(2) The institutional health facility reports the new bed total on its next annual report to the ~~department~~ bureau.

If these conditions are not met, the institutional health facility is subject to review as a "new institutional health service" or "changed institutional health service" under section 135.61, subsection 18, paragraph "d", and subject to sanctions under section 135.73. If the institutional health facility reestablishes the deleted beds at a later time, review as a "new institutional health service" or "changed institutional health service" is required pursuant to section 135.61, subsection 18, paragraph "d".

h. The deletion of one or more health services, previously offered on a regular basis by an institutional health facility or health maintenance organization, notwithstanding any provision of this division to the contrary, if all of the following conditions exist:

(1) The institutional health facility or health maintenance organization reports to the ~~department~~ bureau the deletion of the service or services at least thirty days before the deletion on a form prescribed by the department or bureau.

(2) The institutional health facility or health maintenance organization reports the deletion of the service or services on its next annual report to the ~~department~~ bureau.

If these conditions are not met, the institutional health facility or health maintenance organization is subject to

review as a "new institutional health service" or "changed institutional health service" under section 135.61, subsection 18, paragraph "f", and subject to sanctions under section 135.73.

If the institutional health facility or health maintenance organization reestablishes the deleted service or services at a later time, review as a "new institutional health service" or "changed institutional health service" may be required pursuant to section 135.61, subsection 18.

k. The redistribution of beds by a hospital within the acute care category of bed usage, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:

(1) The hospital reports to the ~~department~~ bureau the number and type of beds to be redistributed on a form prescribed by the department or bureau at least thirty days before the redistribution.

(2) The hospital reports the new distribution of beds on its next annual report to the ~~department~~ bureau.

If these conditions are not met, the redistribution of beds by the hospital is subject to review as a new institutional health service or changed institutional health service pursuant to section 135.61, subsection 18, paragraph "d", and is subject to sanctions under section 135.73.

l. The ~~replacement or~~ modernization of any institutional health facility if the ~~replacement or~~ modernization does not add new health services or additional bed capacity for existing health services~~.~~ and does not relocate the institutional health facility to any other site, notwithstanding any provision in this division to the contrary.

p. The conversion of an existing number of beds by an intermediate care facility for persons with mental retardation to a smaller facility environment, including but not limited to a community=based environment which does not result in an increased number of beds, notwithstanding any provision in this division to the contrary, including subsection 4, if all of the following conditions exist:

(1) The intermediate care facility for persons with mental retardation reports the number and type of beds to be converted on a form prescribed by the department or bureau at least thirty days before the conversion.

(2) The intermediate care facility for persons with mental retardation reports the conversion of beds on its next annual report to the ~~department~~ bureau.

Sec. 44. Section 135.63, subsection 4, unnumbered paragraph 1, Code 2007, is amended to read as follows:

A copy of the application shall be sent to the department of human services at the time the application is submitted to the ~~Iowa department of public health~~ bureau. The ~~department~~ bureau shall not process applications for and the council shall not consider a new or changed institutional health service for an intermediate care facility for persons with mental retardation unless both of the following conditions are met:

Sec. 45. Section 135.64, subsection 1, unnumbered paragraph 1, Code 2007, is amended to read as follows:

In determining whether a certificate of need shall be issued, the ~~department~~ bureau and council shall consider the following:

Sec. 46. Section 135.64, subsection 1, Code 2007, is amended by adding the following new paragraphs before paragraph a:

NEW PARAGRAPH. 0a. The relationship of the proposed institutional health service to the statewide health care delivery infrastructure and resources strategic plan developed by the bureau pursuant to section 135.50.

NEW PARAGRAPH. 1a. Whether the proposed institutional health service promotes wellness and prevention, will improve quality, and will reduce health care costs.

Sec. 47. Section 135.64, subsection 1, paragraphs c, g, h, i, and r, Code 2007, are amended to read as follows:

c. The ~~need~~ specific health care needs of the population served or to be served by the proposed institutional health services for those services, the extent to which the proposed institutional health services will substantially address these specific health care needs, and the projected positive impact that the proposed institutional health services will have on the health status indicators of the population to be served.

g. The relationship of the proposed institutional health services to the state health care delivery infrastructure and

health care workforce resources strategic plan and to the existing health care system of the area in which those services are proposed to be provided.

h. The appropriate and efficient use or prospective use of the proposed institutional health service, and of any existing similar services, including but not limited to a consideration of the capacity of the sponsor's facility to provide the proposed service, and possible sharing or cooperative arrangements among existing facilities and providers; and whether there is a substantial risk that the proposed institutional health services will result in inappropriate increases in service utilization or the cost of health care services.

i. The availability of resources, including, but not limited to, health care providers, management personnel, and funds for capital and operating needs, to provide the proposed institutional health services and the possible alternative uses of those resources to provide other health services; the impact of the proposed institutional health services on total health care expenditures and total health care workforce resources taking into consideration both the costs and benefits of the proposed institutional health services and the competing demands in the local service area statewide for available financial and human resources for health care; and the impact on existing and proposed institutional and other educational training programs for health care providers at the student, internship, and residency training levels.

r. The recommendations of staff personnel of the department or bureau assigned to the area of certificate of need, concerning the application, if requested by the council.

Sec. 48. Section 135.64, subsection 1, Code 2007, is amended by adding the following new paragraph:

NEW PARAGRAPH. ee. Whether the proposed institutional health services will provide demonstrable improvements in quality and outcome measures applicable to the institutional health services proposed.

Sec. 49. Section 135.64, subsection 2, unnumbered paragraph 1, Code 2007, is amended to read as follows:

In addition to the findings required with respect to any of the criteria listed in subsection 1 of this section, the council shall grant a certificate of need for a new institutional health service or changed institutional health service only if it finds in writing, on the basis of data submitted to it by the department or bureau, that:

Sec. 50. Section 135.65, Code 2007, is amended to read as follows:

135.65 LETTER OF INTENT TO PRECEDE APPLICATION == REVIEW AND COMMENT.

1. Before applying for a certificate of need, the sponsor of a proposed new institutional health service or changed institutional health service shall submit to the ~~department~~ bureau a letter of intent to offer or develop a service requiring a certificate of need. The letter shall be submitted as soon as possible after initiation of the applicant's planning process, and in any case not less than thirty days before applying for a certificate of need and before substantial expenditures to offer or develop the service are made. The letter shall include a brief description of the proposed new or changed service, its location, and its estimated cost.

2. Upon request of the sponsor of the proposed new or changed service, the ~~department~~ bureau shall make a preliminary review of the letter for the purpose of informing the sponsor of the project of any factors which may appear likely to result in denial of a certificate of need, based on the criteria for evaluation of applications in section 135.64. A comment by the ~~department~~ bureau under this section shall not constitute a final decision.

Sec. 51. Section 135.66, Code 2007, is amended to read as follows:

135.66 PROCEDURE UPON RECEIPT OF APPLICATION == PUBLIC NOTIFICATION.

1. Within fifteen business days after receipt of an application for a certificate of need, the ~~department~~ bureau shall examine the application for form and completeness and accept or reject it. An application shall be rejected only if it fails to provide all information required by the ~~department~~ bureau pursuant to section 135.63, subsection 1. The ~~department~~ bureau shall promptly return to the applicant any rejected application, with an explanation of the reasons for its rejection.

2. Upon acceptance of an application for a certificate of need, the ~~department~~ bureau shall promptly undertake to notify all affected persons in writing that formal review of the application has been initiated. Notification to those affected persons who are consumers or third=party payers or other payers for health services may be provided by distribution of the pertinent information to the news media.

3. Each application accepted by the ~~department~~ bureau shall be formally reviewed for the purpose of furnishing to the council the information necessary to enable it to determine whether or not to grant the certificate of need. A formal review shall consist at a minimum of the following steps:

a. Evaluation of the application against the criteria specified in section 135.64.

b. A public hearing on the application, to be held prior to completion of the evaluation required by paragraph "a", shall be conducted by the council.

4. When a hearing is to be held pursuant to subsection 3, paragraph "b", the ~~department~~ bureau shall give at least ten days' notice of the time and place of the hearing. At the hearing, any affected person or that person's designated representative shall have the opportunity to present testimony.

Sec. 52. Section 135.67, unnumbered paragraph 1, Code 2007, is amended to read as follows:

The ~~department~~ bureau may waive the letter of intent procedures prescribed by section 135.65 and substitute a summary review procedure, which shall be established by rules of the department, when it accepts an application for a certificate of need for a project which meets any of the criteria in subsections 1 through 5:

Sec. 53. Section 135.67, subsections 3 and 5, Code 2007, are amended to read as follows:

3. A project which will not change the existing bed capacity of the applicant's facility or service, as determined by the ~~department~~ bureau, by more than ten percent or ten beds, whichever is less, over a two=year period.

5. Any other project for which the applicant proposes and the ~~department~~ bureau agrees to summary review.

Sec. 54. Section 135.67, unnumbered paragraph 2, Code 2007, is amended to read as follows:

The ~~department's~~ bureau's decision to disallow a summary review shall be binding upon the applicant.

Sec. 55. Section 135.68, Code 2007, is amended to read as follows:

135.68 STATUS REPORTS ON REVIEW IN PROGRESS.

While formal review of an application for a certificate of need is in progress, the ~~department~~ bureau shall upon request inform any affected person of the status of the review, any findings which have been made in the course of the review, and any other appropriate information concerning the review.

Sec. 56. Section 135.69, unnumbered paragraph 1, Code 2007, is amended to read as follows:

The ~~department~~ bureau shall complete its formal review of the application within ninety days after acceptance of the application, except as otherwise provided by section 135.72, subsection 4. Upon completion of the formal review, the council shall approve or deny the application. The council shall issue written findings stating the basis for its decision on the application, and the ~~department~~ bureau shall send copies of the council's decision and the written findings supporting the decision to the applicant and to any other person who so requests.

Sec. 57. Section 135.71, Code 2007, is amended to read as follows:

135.71 PERIOD FOR WHICH CERTIFICATE IS VALID == EXTENSION OR REVOCATION.

A certificate of need shall be valid for a maximum of one year from the date of issuance. Upon the expiration of the certificate, or at any earlier time while the certificate is valid the holder ~~thereof~~ shall provide the ~~department~~ bureau such information on the development of the project covered by the certificate as the ~~department~~ bureau may request. The council shall determine at the end of the certification period whether sufficient progress is being made on the development of the project. The certificate of need may be extended by the council for additional periods of time as are reasonably necessary to expeditiously complete the project, but may be revoked by the council at the end of the first or any subsequent certification period for insufficient progress in

developing the project.

Upon expiration of certificate of need, and prior to extension thereof, any affected person shall have the right to submit to the ~~department~~ bureau information which may be relevant to the question of granting an extension. The ~~department~~ bureau may call a public hearing for this purpose.

Sec. 58. Section 135.72, subsection 4, Code 2007, is amended to read as follows:

4. Criteria for determining when it is not feasible to complete formal review of an application for a certificate of need within the time limits specified in section 135.69. The rules adopted under this subsection shall include criteria for determining whether an application proposes introduction of technologically innovative equipment, and if so, procedures to be followed in reviewing the application. However, a rule adopted under this subsection shall not permit a deferral of more than sixty days beyond the time when a decision is required under section 135.69, unless both the applicant and the ~~department~~ bureau agree to a longer deferment.

Sec. 59. Section 135.74, subsections 1 and 2, Code 2007, are amended to read as follows:

1. The department, after study and in consultation with the bureau of health care quality and consumer information and any advisory committees which may be established pursuant to law, shall promulgate by rule pursuant to chapter 17A uniform methods of financial reporting, including such allocation methods as may be prescribed, by which hospitals and health care facilities shall respectively record their revenues, expenses, other income, other outlays, assets and liabilities, and units of service, according to functional activity center. These uniform methods of financial reporting shall not preclude a hospital or health care facility from using any accounting methods for its own purposes provided these accounting methods can be reconciled to the uniform methods of financial reporting prescribed by the department and can be audited for validity and completeness. Each hospital and each health care facility shall adopt the appropriate system for its fiscal year~~, effective upon such date as the department shall direct. In determining the effective date for reporting requirements, the department shall consider both the immediate need for uniform reporting of information to effectuate the purposes of this division and the administrative and economic difficulties which hospitals and health care facilities may encounter in complying with the uniform financial reporting requirement, but the effective date shall not be later than January 1, 1980~~.

2. In establishing uniform methods of financial reporting, the department shall consider all of the following:

a. The existing systems of accounting and reporting currently utilized by hospitals and health care facilities~~;~~.

b. Differences among hospitals and health care facilities, respectively, according to size, financial structure, methods of payment for services, and scope, type and method of providing services~~; and~~.

c. Other pertinent distinguishing factors.

Sec. 60. Section 135.75, subsection 1, Code 2007, is amended to read as follows:

1. Each hospital and each health care facility shall annually, after the close of its fiscal year, file with the department all of the following:

a. A balance sheet detailing the assets, liabilities and net worth of the hospital or health care facility~~;~~.

b. A statement of ~~its~~ the hospital's or health care facility's income and expenses~~; and~~ including but not limited to expenses for salaries and other compensation for management positions including the salary and compensation for the chief executive officer and five other most highly compensated positions, profit or excess revenues, and cash reserves.

c. Such other reports of the costs incurred in rendering services as the department may prescribe.

Sec. 61. Section 135.76, Code 2007, is amended to read as follows:

135.76 ANALYSES AND STUDIES BY ~~DEPARTMENT~~ BUREAU.

1. The ~~department~~ bureau of health care strategic planning and resource development, in cooperation with the bureau of health care quality and consumer information, shall from time to time undertake analyses and studies relating to hospital and health care facility costs and to the financial status of hospitals or health care facilities, or both, which are subject to the provisions of this division. ~~It~~ The bureau of health care strategic planning and resource development shall

~~further~~ also require the filing of information concerning the total financial needs of each individual hospital or health care facility and the resources currently or prospectively available to meet these needs, including the effect of proposals made by health systems agencies. The ~~department~~ bureau shall also prepare and file such summaries and compilations or other supplementary reports based on the information filed with ~~it~~ the bureau as will, in ~~its~~ the bureau's judgment, advance the purposes of this division and the purposes of the bureau of health care quality and consumer information.

2. The analyses and studies required by this section shall be conducted with the objective of providing a basis for determining whether or not regulation of hospital and health care facility rates and charges by the state of Iowa is necessary to protect the health or welfare of the people of the state.

3. In conducting ~~its~~ the analyses and studies, the ~~department should~~ bureau shall determine whether:

a. The rates charged and costs incurred by hospitals and health care facilities are reasonably related to the services offered by those respective groups of institutions.

b. Aggregate rates of hospitals and of health care facilities are reasonably related to the aggregate costs incurred by those respective groups of institutions.

c. Rates are set equitably among all purchasers or classes of purchasers of hospital and of health care facility services.

d. The rates for particular services, supplies or materials established by hospitals and by health care facilities are reasonable. Determination of reasonableness of rates shall include consideration of a fair rate of return to proprietary hospitals and health care facilities.

4. All data gathered and compiled and all reports prepared under this section, except privileged medical information, shall be open to public inspection.

Sec. 62. Section 135.78, Code 2007, is amended to read as follows:

135.78 DATA TO BE COMPILED.

The ~~department~~ bureau of health care strategic planning and resource development shall compile all relevant financial and utilization data in order to have available the statistical information necessary to properly monitor hospital and health care facility charges and costs and to assist the bureau of health care quality and consumer information. Such data shall include necessary operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved. The ~~department~~ bureau of health care strategic planning and resource development shall also obtain from each hospital and health care facility a current rate schedule as well as any subsequent amendments or modifications of that schedule as it may require. In collection of the data required by this section and sections 135.74 through 135.76, the ~~department~~ bureau of health care strategic planning and resource development, the bureau of health care quality and consumer information, and other state agencies shall coordinate their reporting requirements.

EXPLANATION

IOWA HEALTH CARE COVERAGE EXCHANGE. Division I of this bill relates to the creation of the Iowa health care coverage exchange in new Code chapter 514M with the intent to progress toward achievement of the goal that all Iowans have health care coverage, as funding becomes available.

Specified priorities for achievement of the goal are as follows:

1. All Iowa children have qualified health care coverage which meets certain standards of quality and affordability beginning with covering all children who are eligible for public coverage by December 31, 2009, subsidizing private coverage for the remaining uninsured children up to 18 years of age under a sliding scale based on family income by December 31, 2009, and moving toward a future requirement that all parents provide proof of qualified health care coverage for their children.

2. All Iowans have qualified health care coverage which meets certain standards of quality and affordability beginning with continued expansion of options for individuals who are dually eligible for Medicare and medical assistance,

facilitating coverage of uninsured health and long=term care workers and child care workers, maximizing eligibility of low=income adults 18 years of age and older for public health care coverage, subsidizing coverage for the remaining low=income adults, and moving toward a future requirement that all Iowans must provide proof of qualified health care coverage.

3. Health care costs and health care coverage costs are decreased by instituting insurance reforms, requiring Iowa children with public coverage to have a medical home, establishing a statewide telehealth system, and implementing cost=containment strategies.

The Iowa health care coverage exchange is created as a state agency governed by a board of directors including the following nine voting members: the two most recent former governors (or if one or both of them are unable or unwilling to serve, a person or persons appointed by the governor); the commissioner of insurance; the director of human services; and five members appointed by the governor subject to confirmation by the senate; who represent specified groups; and including the following five ex officio, nonvoting members: four members of the general assembly and a secretary of the board. The voting members of the board are also required to appoint an executive director, subject to confirmation by the senate, to supervise the administrative affairs and general management and operations of the exchange.

The bill provides that the board has broad authority to accomplish the purposes of the Code chapter including but not limited to many specified powers and duties. The board is required to make an annual report of its activities and receipts and expenditures to the governor and general assembly. A separate health care coverage exchange fund is created in the state treasury under the control of the exchange. Moneys collected from premiums paid for health care plans offered by the exchange as well as any other moneys that are appropriated or transferred to the fund are appropriated to the fund and available to the exchange to carry out the purposes of new Code chapter 514M.

The bill provides for transition provisions during implementation of health care coverage for all Iowans. The board is directed to design and implement a program, as funding becomes available, including a timetable and procedures for implementation, to progress toward achieving the goal that all Iowans have qualified health care coverage. The board is charged to define what constitutes such coverage, including parameters of quality and affordability.

MEDICAL HOME. Division II of the bill relates to medical homes. The bill provides definitions, including the definition of a medical home which is a team approach to providing health care that originates in a primary care setting, and provides for continuity in and coordination of care. The bill specifies the characteristics of a medical home, and creates a medical home commission. The commission is directed to develop a plan for implementation of a statewide medical home system. Implementation is to take place in phases, beginning with children who are recipients of medical assistance (Medicaid) or the hawk=i program and expanding to children covered through the exchange created in the bill. The second phase would provide a medical home to adults under the IowaCare program and adult recipients of Medicaid. The third phase would provide for a medical home for adults covered through the exchange.

The bill specifies the duties of the medical home commission and the organizational structure for the medical home system. The bill directs the commission to adopt standards and a process to certify medical homes based on national standards, to adopt education and training standards for health care professionals participating in the medical home system, to provide for system simplification, to determine a rate of reimbursement and recommend incentives for participation in the medical home system, and to coordinate efforts with the dental home for children, and integrate the recommendations of the prevention and chronic care management advisory council into the medical home system.

In addition to the phased=in implementation, the bill also directs the commission to work with the department of administrative services to allow state employees to utilize the medical home system, to work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system and to work with insurers and

self=insured companies to allow those with private insurance to access the medical home system. The commission is directed to provide oversight for the medical home system and to evaluate and make recommendations regarding improvements to and continuation of the medical home system.

PREVENTION AND CHRONIC CARE MANAGEMENT. Division III relates to prevention and chronic care management. The bill provides definitions relating to chronic conditions and chronic care and for the state initiative for prevention and chronic care management.

The bill creates an advisory council to assist the director of public health in developing the state initiative. The advisory council is directed to elicit input from a variety of health care professionals, organizations, insurers, businesses, and consumers and is to submit initial recommendations to the director by July 1, 2009. The recommendations are to address the organizational structure for integrating chronic care management into the public and private health care systems, a process for identifying leading health care professionals and existing programs to coordinate efforts, prioritization of chronic conditions, a method to involve health care professionals in identifying individuals with chronic conditions, methods to increase communication between health care professionals and patients with chronic conditions, protocols and tools for health care providers to utilize, outcomes measures and benchmarks, payment methodologies and incentives, ways to involve public and private entities in facilitating and sustaining the initiative, alignment of information technology, involvement of health resources and researchers to collect data and evaluate the initiative, a marketing campaign, a means of determining participation in the initiative, and a means to integrate chronic care management into education resources and curricula for existing and new education and training programs.

The bill provides that following initial recommendations and implementation among the eligible population of individuals (residents of the state who have been diagnosed with a chronic condition or who are at elevated risk for a chronic condition and who are recipients of medical assistance, the hawk=i program, or IowaCare; an inmate of a correctional institution; or an individual who has qualified health care coverage through the exchange), the director is required to work with various entities to implement the initiative as an integral part of the health care delivery system in the state.

The bill also directs the department of administrative services to include in any request for proposals for the administration of health benefit plans for state employees a request for a description of any prevention and chronic care management program provided by the entity offering the health benefit plan.

IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM. Division IV relates to the Iowa health information technology system. The bill provides definitions, principles, and goals for the system. The bill creates an electronic health information commission as a public and private collaborative effort and directs the commission to establish an advisory council to assist the commission in its duties; to adopt a statewide health information technology plan by January 1, 2009; to identify existing efforts and integrate these efforts to avoid incompatibility and duplication; to coordinate public and private efforts to provide the network backbone; to promote the use of telemedicine; to address the workforce needs generated by increased use of health information technology; to adopt necessary rules; to coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in the state; to seek and apply for federal or private funding to assist in implementing the system; and to identify state laws and rules that present barriers to the development of the health information technology system in the state.

The bill requires that by January 1, 2010, all health care professionals utilize the patient identifier and continuity of care record specified by the commission.

LONG=TERM CARE PLANNING AND ADVANCE MEDICAL DIRECTIVES. Division V relates to long=term care planning and advance medical directives. The bill provides that under the life=sustaining procedures Act, the hospital or health care provider is required to use a physician orders for life=sustaining=treatment form reflecting the declaration of a

patient and to ensure that the form accompanies a patient who is comatose, incompetent, or otherwise physically or mentally incapable of communication if the patient is transferred to another facility.

The bill also requires that under the life=sustaining procedures Act and the durable power of attorney for health care chapter hospitals and health care providers establish a nonjudicial means of resolving disputes that arise out of a disagreement over compliance with a declaration or out=of=hospital do=not=resuscitate order or a durable power of attorney for health care.

The bill includes provisions to promote the use of palliative care and to mandate coverage benefits for the cost of core services by a licensed hospice program in a policy or contract providing third=party payment or prepayment of health or medical expenses.

The bill directs programs within the department of elder affairs and other appropriate agencies and interested parties to collaborate in recommending a public education strategy on long=term living. The bill also directs the department of elder affairs in collaboration with the insurance division to implement a long=term care options public education campaign. The bill directs the department of elder affairs to work with other public and private agencies to identify resources to use to continue the work of the aging and disability resource center.

DIVISION OF HEALTH CARE QUALITY, CONSUMER INFORMATION, STRATEGIC PLANNING, AND RESOURCE DEVELOPMENT. Division VI creates the division of health care quality, consumer information, strategic planning, and resource development within the department of public health and specifies two bureaus within the division: the bureau of health care quality and consumer information and the bureau of health care strategic planning and resource development.

The bill requires the bureau of health care quality and consumer information to provide better coordination of health care delivery information to improve the public health, inform policy analysis, and provide transparency of consumer health information. The bill creates a health quality and cost=containment collaborative to develop a process and the infrastructure to provide price, quality, safety, and other appropriate information to consumers. The bill designates the members of the collaborative and specifies its duties.

The bill directs the bureau of health care strategic planning and resource development to coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well=qualified, diverse, and sustainable health care workforce in the state. One duty of the bureau is to develop a strategic plan for health care delivery infrastructure and health care workforce resources. The bureau is directed to establish a technical advisory committee to assist in the development of the strategic plan. The strategic plan is to include policies and goals based on specified principles, a health care system assessment and objectives component, a health care facilities and services plan to assess the demand for health care facilities and services, a health care data resources plan, an assessment of emerging trends in health care delivery and technology, a rural health resources plan, and a health care workforce resources plan.

CERTIFICATE OF NEED PROGRAM. Division VII of the bill amends the certificate of need program to reflect the change of the health facilities council to the health care strategic planning council as the oversight body for the certificate of need program and to require the submission of additional information by those entities subject to the certificate of need program.

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